This form may be completed online, printed and mailed to the address listed below. Attachment A

STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGULATION AND LICENSURE - Credentialing Division
P.O. Box 94986, Lincoln, Nebraska 68509-4986
402-471-2117

APPLICATION FOR A MASSAGE THERAPY LICENSE

Please Type or Print Clearly

It is your responsibility to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

SECTION A - PERSONAL INFORMATION (All applicants must complete this section) This information is public and on the INTERNET under www.hhs.state.ne.us/lis/lisindex.htm

1. Name:	First:	Middle/MI:	Last:
2. Public Address:	Street/PO/Route:		
	City:	State:	Zip:
3. OPTIONAL -Telephone:			
4. Social Security Number: (this is NOT public information and will not be on the Internet) It is required for child support enforcement purposes; and for potential disclosure of reportable actions to the Federal department of Health and Human Service's Healthcare Integrity and Protection Data Bank (HIPDB)			Social Security #:
5. Date of Birth:	6. Place of Birth:		

(Attach proof of age: i.e., copy of birth certificate, school transcript, marriage license, passport, driver's license, etc.)

SECTION B - EXAMINATION. (All applicants must complete this section.)

- ❒ I have registered to take the _____ (month) examination.
- ❒ I have enclosed the official score report given to me by NCTMB at the time of the examination.
- ❒ I have requested NCTMB send an official copy of my score report to your office.
- ❒ I have previously failed the NCTMB examination on _____ (month/day/year).

SECTION C - LICENSE APPLICATION CATEGORY. (All applicants must complete this section)

Check all categories that apply:	Required Fee
Initial Licensure	See Chart Below
License in Another Jurisdiction (State) - Reciprocity	See Chart Below
Temporary Licensure	$ 15.00

To determine the fee due, see the cart below:

YEAR	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Even Numbered Year	27	27	27	27	27	27	27	27	27	27	26	26
Odd Numbered Year	26	26	26	26	26	26	26	26	26	26	27	27

Make payable to: CREDENTIALING DIVISION

NOTE: Licenses expire November 1st of odd-numbered years.

SECTION D – CONVICTION/LICENSURE INFORMATION (Applicants must complete this section)

Questions	Yes	No	Type of Crime or Licensure Action	Date of Action	Name of Court (City/County/State) or Entity taking Action
Have you ever been convicted of a misdemeanor or felony?	❒	❒			

If you answered YES to any of the questions above, you must request the following documents be sent directly to this office:

- Official Court Record, which includes charges and disposition
- Copies of Arrest Records
- A letter from the applicant explaining the nature of the conviction
- All addiction/mental health evaluations and proof of treatment (if the conviction involved a drug and/or alcohol)
- If currently on probation, a letter from your probation officer referencing your probationary progress or date of release

Questions	Yes	No			
Are you licensed or certified in another state?	❒	❒	If yes, what State are you licensed in?		What type of license do you hold?
Have you ever surrendered your license or certification?	❒	❒	Type of Licensure Action	Date of Action	Name of Entity taking Action
Has action been taken to suspend or revoke your license or certification?	❒	❒	Type of Licensure Action	Date of Action	Name of Entity taking Action

If you answered YES to any of the questions above, you must request the following documents be sent directly to this office:

- Official Documents from the State Board in which the disciplinary action was taken
- Certification of your license/certificate in another state (Attachment A1).

SECTION E - EDUCATION. (All applicants must complete this section).

School of Massage Therapy Attended:	Name:		
School Address:	Street/PO/Route:		
	City:	State:	Zip:
Date Completed:	Date:		

The school must submit an official transcript to the Credentialing Division.

SECTION F – ATTESTATION An individual who practices prior to issuance of a credential is subject to assessment of an Administrative Penalty of $10 per day up to $1,000, or such other action as provided in the statutes and regulations governing the credential.

I hereby state that I am the person making application, I am of good moral character, and the statements on this application are true and complete.

I further state that:

❑ I have not practiced in Nebraska without a massage therapy credential prior to this application for licensure; **or**

❑ I have practiced in Nebraska without a massage therapy credential prior to this application for licensure (does not include the time you may have held a temporary license).

____ number of days in Nebraska prior to July 1, 2004

____ number of days in Nebraska after July 1, 2004

_____

(Signature of Applicant)

_____ date

SECTION G - TEMPORARY LICENSE (Complete this section if you want a temporary license.)

NOTE: To be eligible for a temporary license, the following must be submitted: an official transcript verifying graduation from an approved 1,000 hour massage therapy school which includes the specific hour break-down and this entire application for massage therapy licensure. (applicants who have previously taken or failed the examination are NOT eligible for a temporary license.)

Hour break-down is as follows:

A. 100 hours of training in each of the following:
- physiology;
- anatomy;
- massage;
- pathology;
- hydrotherapy
- hygiene and practical demonstration;
- health service management; and

B. 300 hours relating to the clinical practice of massage therapy.

◆ Temporary Applicant completes the following Section: Supervisor/Employment Information

1st Supervising Massage Therapist:	First:	Middle:	Last:	
License Number:	#:			
Names of other Supervising Massage Therapists:	First:	Middle:	Last:	
	License Number #:			
	First:	Middle:	Last:	
	License Number #:			
	First:	Middle:	Last:	
	License Number #:			
Name/Address of Establishment where practice will occur:	Name of Establishment:			
	Street/Route:			
	City:	State:	Zip:	
Establishment License #:	#			

◆ Supervisor(s) complete the following Section:

I hereby state that the foregoing statement is true. I (we) agree to supervise the aforenamed applicant for a temporary massage therapy license in accordance with the laws of Nebraska and the regulations duly promulgated thereunder.

_____ _____ date
Signature of Supervising Massage Therapist

_____ _____ date
Signature of Supervising Massage Therapist

_____ _____ date
Signature of Supervising Massage Therapist

_____ _____ date
Signature of Supervising Massage Therapist

SECTION H - LICENSE ISSUED ON BASIS OF LICENSE IN ANOTHER JURISDICTION. If you hold a license to practice massage therapy in another state or jurisdiction, complete this section and have licensing agency complete the Certification of Massage Therapy license. (Attachment A3)

Name of Agency Issuing License:	Name:			
Address:	Street/PO/Route:			
	City:	State:	Zip:	

1	Date License Issued:		
2	Name of Written Examination:		
3	Did you take a Practical Examination: (A practical examination is required - such examination may be administered by the school of massage therapy as a condition of graduation, or by the State in which you are licensed as a condition of licensure.)	Yes ❒	No ❒
4	Nebraska requires completion of at least 1,000 hours of training in massage therapy with specific hours in various subjects as outlined in the regulations (172 NAC 81-002). Have you completed such training?	Yes ❒	No ❒
5	Have you been actively engaged in the practice of massage therapy under such license or in accepted residency or graduate program for one year of the three years immediately preceding the date of application for Nebraska license?	Yes ❒	No ❒

5a If in an accepted residency or graduate program, provide the name of the facility or graduate program, address, and dates actively engaged in the practice of massage therapy. (Continue on reverse side or use an additional sheet if space is inadequate.)

Facility/ Employment:	Name:		
Address:	Street/PO/Route:		
	City:	State:	Zip:

Facility/ Employment:	Name:		
Address:	Street/PO/Route:		
	City:	State:	Zip:

6	Have you been in active and continuous practice of massage therapy under license by examination in the state, territory, or District of Columbia from which you come for at least one year following the issuance of such license?	Yes ❒	No ❒

6a Give location, address, and dates actively engaged in practice of massage therapy. (Use an additional sheet if space is inadequate.)

Facility/ Employment:	Name:		
Address:	Street/PO/Route:		
	City:	State:	Zip:

Facility/ Employment:	Name:		
Address:	Street/PO/Route:		
	City:	State:	Zip:

7	Have you requested to have certification of your massage therapy license sent to Nebraska by submitting to the appropriate licensing agency the Certification of Applicant's License In Massage Therapy (Attachment A-1)?	Yes ❒	No ❒

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This form must be completed by the state licensing board in each state for which the applicant is licensed. **(Print or Type)**

CERTIFICATION OF A LICENSE AS A MASSAGE THERAPIST

Our records indicate that _____ was licensed as a

(Applicant's Name)

massage therapist on _____, _____. The license was issued on the basis of a written & practical

examination _____. The applicant's score was _____ _____.
(Name of Written Examination) (written) (practical)

Number of hours of training in the Massage Therapy School was _____

It is further verified that based on the records in this department the applicant's license has been:

(a) suspended ❒ Yes ❒ No;
(b) revoked ❒ Yes ❒ No;
(c) had other disciplinary action ❒ Yes ❒ No;

If yes to any of the above, please explain: _____

_____

and

(d) has been maintained in good standing up to and including the present date ❒ yes ❒ no

So far as the record of this agency is concerned, the applicant is entitled to the endorsement of this agency.

Date:_____

_____
Name and Title

Optional:_____
Area Code/Telephone Number

_____
Licensing Agency

_____
Address

_____
City/State/Zip Code

_____
Signature (NO STAMP)

FORWARD THIS COMPLETED FORM TO:

Credentialing Division
P.O. Box 94986
Lincoln, Nebraska 68509-4986